



MARYLAND  
Department of Health

## Maryland Primary Care Program (MDPCP) FAQs

The following document contains responses to the most Frequently Asked Questions (FAQs) about the Maryland Primary Care Program (MDPCP). Additional information, reference materials, educational webinars, and other resources can be found on the MDPCP website, at:

<https://health.maryland.gov/MDPCP/Pages/home.aspx>.

Separate resource libraries are available for Practices and Care Transformation Organizations (CTOs):

- Practices: <https://health.maryland.gov/mdpcp/Pages/practices.aspx>
- CTOs: <https://health.maryland.gov/mdpcp/Pages/care-transformation-organizations.aspx>

**Disclaimer:** This series of FAQs is not endorsed by CMS and is meant to serve as a guidance document only. Any additional questions should be directed to [MarylandModel@cms.hhs.gov](mailto:MarylandModel@cms.hhs.gov), or 844-711-CMMI, Option 7.

### General

**1. When will the MDPCP start and end?**

The MDPCP will begin on January 1, 2019, and end on December 31, 2026.

**2. When may practices and CTOs apply?**

CMS will accept CTO applications between 6/8/18-7/23/18. CMS will announce CTO selections in August of 2018. Practices will be able to apply between 8/1/18 -8/31/18. Practices will be selected and announced in the fall of 2018. Practice and CTO partnerships will be announced later in the fall of 2018. Practices and CTOs that do not apply during the initial application period or that are not selected to participate in the initial Performance Year may apply to participate in a future Performance Year. The last application period will occur in calendar year 2023 for the 2024 Performance Year.

**3. Are participants required to participate in MDPCP for the entirety of the program?**

CMS expects that practices who participate will do so for all of the performance periods. MDPCP is a voluntary program, and practices may withdraw without penalty. Practices and CTOs will be required to notify CMS at least 90 calendar days before the planned withdrawal date. Participants departing the program before the completion of a performance period puts the practice at risk for recoupment of the prospectively paid performance based incentive payment.

**4. What are the five Comprehensive Primary Care functions of Advanced Primary Care?**

- Care Management
- Access and Continuity

- Planned Care for Health Outcomes
- Beneficiary and Caregiver Experience
- Comprehensiveness and Coordination Across the Continuum of Care

More information on the 5 functions can be found in the Request for Applications (RFA), which is available at: <https://innovation.cms.gov/Files/x/mdtcocm-rfa.pdf>.

## **5. Where should I go if I have questions about the Program?**

The MDPCP has a mailbox where questions can be submitted: [MarylandModel@cms.hhs.gov](mailto:MarylandModel@cms.hhs.gov). Applicants can also call the Helpdesk Phonenumber at 844-711-CMMI, Option 7. Additional information can be found at <https://health.maryland.gov/mdpcp/Pages/home.aspx>

## **Eligibility**

### **1. Who are the eligible practitioners?**

Primary care practitioners with a primary specialty code of General Practice (01), Family Medicine (08), Internal Medicine (11), Obstetrics and Gynecology (16), Pediatric Medicine (37), Geriatric Medicine (38), Nurse Practitioner (50), Clinical Nurse Specialist (89), Psychiatry (26) and Physician Assistant (97) are eligible. Nurse practitioners, Certified Nurse Specialists, and Physician Assistants must be in one of the aforementioned primary care specialties. Practitioners identified with a primary specialty code of Psychiatry (26) must be co-located in a practice with an eligible practitioner with a primary specialty code other than Psychiatry in order to participate in the MDPCP. Practitioners must be part of an eligible practice, as defined in Eligibility Question #3 below.

### **2. Are practices outside of MD eligible to apply and participate in the MDPCP?**

Practices are only eligible to apply if their practice site address is in the state of Maryland.

### **3. In order to be eligible to participate in the MDPCP as a Participant Practice, what criteria does the applicant need to meet?**

- The practice and all NPIs on the applicant's Practitioner Roster must be enrolled in Medicare;
- The practice must maintain a minimum of 125 attributed Medicare FFS beneficiaries during each performance year;
- The practice and all NPIs on the applicant's Practitioner Roster must submit Medicare FFS claims on a Medicare Physician/Supplier claim form (Form 837P or Form 1500) and be paid under the Medicare Physician Fee Schedule for office visits; and
- The practice must meet additional requirements under the participation agreement entered into by the practice and CMS (the "Practice Participation Agreement"). Program participants will be subject to a program integrity screening. CMS may reject an application or terminate a participation agreement on the basis of the results of a program integrity screening.

- e. Using certified electronic health record technology (CEHRT), 2014 edition or later.
- 4. How does the MDPCP impact specialists who are not directly eligible to participate in the program?**

The MDPCP is currently open to physicians, clinical nurse specialists, nurse practitioners, and physician assistants with a specific subset of specialty designations, including: General Practice, Family Medicine, Internal Medicine, Obstetrics and Gynecology, Pediatric Medicine, Geriatric Medicine, and co-located Psychiatry. While direct entry into the program is limited to primary care practitioners and these specialties, primary care practitioners in the program will be encouraged to work collaboratively with the specialists that they frequently use to coordinate care.

Practices will be expected to work closely with specialists that they refer to and establish processes for efficiently managing the continuum of care. Practices that participate in the MDPCP will also receive feedback on the frequency of service utilization and associated costs for all of their attributed Medicare beneficiaries.

## Program Overlaps

**1. Can a practice be in both an ACO and the MDPCP?**

Yes, practitioners meeting the eligibility criteria are eligible to participate in the Model even if they also participate in a Medicare Shared Savings Program (MSSP) ACO. They will be subject to the same restrictions as any other provider including meeting program integrity standards and the participation agreement. Specific overlap restrictions are as follows:

- a. Not charge any concierge fees to Medicare beneficiaries
- b. Not be a participant in certain other CMMI initiatives including Accountable Care Organization [ACO] Investment Model, Next Generation ACO Model, and Comprehensive ESRD Care Model
- c. Not be a participant in a Rural Health Clinic or a Federally Qualified Health Center

**2. Can a practice be in both the Care Redesign Program (CRP) and the MDPCP?**

Certain CRP Tracks may contain restrictions (“Care Partner Qualifications”) that either prohibit or limit MDPCP practitioners from participating in a certain CRP Track as a Care Partner. For instance, simultaneous enrollment in MDPCP and the Chronic Care Improvement Program (CCIP) will not be allowed for 2019. The option for dual enrollment may be considered in future years.

**3. How will payments work with practices participating in both the MDPCP and MSSP?**

Practices that participate in the MDPCP may also participate in a Medicare Shared Savings Program ACO. However, CMS will not pay shared savings and Performance-Based Incentive Payments (PBIPs) for the same beneficiary. If a practice is a dual participant in the MDPCP and the Medicare Shared Savings Program, the MDPCP practice will not receive any portion of the annual PBIP for the MDPCP performance year in which such dual participation occurs. In addition, the CPCPs and CMFs paid to the practice are included in assessing the ACO’s expenditures for purposes of calculating shared savings or shared losses. Similarly, CTOs will not receive a PBIP for any practice that is in an ACO. Unless otherwise noted in the Practice

Participation Agreement, practices are free to simultaneously participate in other CMMI models while participating in the MDPCP.

For more information, the State has also published an unofficial Model Overlap guidance document available at:

<https://health.maryland.gov/mdpcp/Documents/MDPCP%20Model%20Overlap.pdf>.

CMS will make all final determinations regarding MACRA status. For specific questions about your MACRA status, email [QPP@cms.hhs.gov](mailto:QPP@cms.hhs.gov).

## Application

### **1. How will CMS assess a practice's application?**

CMS will be able to access each application through the application portal, and will assess whether the practice will be able to meet the care transformation requirements based upon information provided in the application. Practices will also need to meet minimum eligibility requirements, including meeting program integrity standards, using certified electronic health record technology (CEHRT), and provide services to a minimum of 125 attributed Medicare fee-for-service beneficiaries.

### **2. What happens if a practice is not accepted into the MDPCP?**

The practice may reapply during the next application period, which will be for participation the following program year.

### **3. What happens after a participant is accepted into the MDPCP?**

CTO participants will be notified shortly after August 1st. Practices will be notified within 60 days of the application closing date whether they have been accepted into the MDPCP. Each accepted participant wishing to participate will then sign a participation agreement with CMS and provide CMS with payment information. Participants will then be provided with on-boarding materials and information by the State and CMS in order to be prepared to begin at the start of the calendar year.

## Track Requirements

### **1. What are the tracks for the MDPCP?**

Track 1 (Standard Track): Track 1 practices must indicate their capability to deliver the five Comprehensive Primary Care Functions at the time they submit applications.

Track 2 (Advanced Track): Track 2 practices must demonstrate capability to deliver the five Comprehensive Primary Care Functions at the time they submit applications. These practices must also have both advanced HIT capabilities and the ability to provide a greater depth and scope of care than the Track 1 practices. Track 2 practices must also be willing to accept the hybrid CPCP payment stream.

### **2. Will practices be able to choose their track during the application process?**

Practices will indicate, in the application, for which track they would like to be considered. CMS will take the practices' track preference under consideration during the application review process. If the practice applies to participate in Track 2, but is not accepted, they will be considered for Track 1.

## Care Transformation Requirements

### 1. What is the purpose of the care transformation requirements?

All practices will be required to meet the care transformation requirements for their respective tracks in each of the five Comprehensive Primary Care Functions of Advanced Primary Care. The care transformation requirements are intended to guide practices towards transforming to Advanced Primary Care and can be found in the *Getting Started with MDPCP* guide.

### 2. Where can the practice acquire more information about the care transformation requirements?

More information about the care transformation requirements will be available in the *Getting Started with the MDPCP* guide and support for meeting those requirements will be offered through the Learning System. An overview of the 2019 care transformation requirements for each track is provided in the table below.

*MDPCP Care Transformation Requirements 2019 Table*

	MDPCP Track 1	MDPCP Track 2 Track 2 practices must meet all Track 1 requirements plus:
Access and Continuity	<ul style="list-style-type: none"> <li>Empanel attributed beneficiaries to practitioner or care team.</li> <li>Ensure attributed beneficiaries have 24/7 access to a care team or practitioner with real-time access to the EHR.</li> </ul>	<ul style="list-style-type: none"> <li>Ensure attributed beneficiaries have regular access to the care team or practitioner through at least one alternative care strategy.</li> </ul>
Care Management	<ul style="list-style-type: none"> <li>Ensure all empaneled, attributed beneficiaries are risk stratified.</li> <li>Ensure all attributed beneficiaries identified as increased risk and likely to benefit receive targeted, proactive, relationship-based (longitudinal) care management.</li> <li>Ensure attributed beneficiaries receive a follow-up interaction from your practice within one week for ED discharges and two business days for hospital discharges.</li> <li>Ensure targeted, attributed beneficiaries who have received follow-up after ED, hospital discharge, or other triggering event receive short-term (episodic) care</li> </ul>	<ul style="list-style-type: none"> <li>Ensure attributed beneficiaries in longitudinal care management are engaged in a personalized care planning process, which includes at least their goals, needs, and self-management activities.</li> <li>Ensure attributed beneficiaries in longitudinal care management have access to comprehensive medication management.</li> </ul>

	MDPCP Track 1	MDPCP Track 2 Track 2 practices must meet all Track 1 requirements plus:
	management.	
Comprehensiveness and Coordination across the Continuum of Care	<ul style="list-style-type: none"> <li>• Ensure coordinated referral management for attributed beneficiaries seeking care from high-volume and/or high-cost specialists as well as EDs and hospitals.</li> <li>• Ensure attributed beneficiaries with behavioral health needs have access to care consistent with at least one option from a menu of options for integrated behavioral health supplied to attributed beneficiaries by the Practice</li> </ul>	<ul style="list-style-type: none"> <li>• Facilitate access to resources that are available in your community for beneficiaries with identified health-related social needs</li> </ul>
Beneficiary & Caregiver Experience	<ul style="list-style-type: none"> <li>• Convene a Patient-Family/ Caregiver Advisory Council (PFAC) at least annually and integrate PFAC recommendations into care and quality improvement activities.</li> </ul>	<ul style="list-style-type: none"> <li>• Engage attributed beneficiaries and caregivers in a collaborative process for advance care planning</li> </ul>
Planned Care for Health Outcomes	<ul style="list-style-type: none"> <li>• Continuously improve your performance on key outcomes, including cost of care, electronic clinical quality measures, beneficiary experience, and utilization measures.</li> </ul>	

### 3. How does CMS know whether practices have successfully met the care transformation requirements?

Practices will report quarterly, to CMS, their progress towards meeting the care transformation requirements, in the MDPCP Portal. Practices will be provided feedback on their performance to identify opportunities for improvement

### 4. What happens if a practice does not meet all of the care transformation requirements?

Practices will be given additional assistance and support to meet care transformation requirements. If a practice still does not meet all of the care transformation requirements, they may be put on a corrective action plan (CAP) and provided further technical support to meet the requirements.

Each participating practice will need to meet the care delivery requirements or milestones for their Track. CMS will monitor the progress of each practice through periodic surveys, quality measures, and cost and utilization data. Practices will be supported by a Learning System to help them meet those requirements as well as monitoring to ensure they are meeting the requirements. Practices will be provided an expected schedule of progression on the care transformation requirements.

**5. What if a practice has a question about one of the care transformation requirements?**

During the Program, practices will have access to a Learning System contractor who can answer questions about the requirements. CMS and the State will offer technical assistance, and a CTO, if selected, may also provide support.

**6. What are the requirements around the use of telehealth, particularly for Behavioral Health (BH)?**

Under MDPCP telehealth should continue to be billed per Medicare guidelines and regulations. There are no changes to Medicare telehealth billing under MDPCP. There are also no telehealth waivers under MDPCP although this may change in the future. Telehealth is an option for embedded BH and can be used to satisfy co-location requirement under MDPCP Care Transformation Requirements. The CMF can be used to hire a BH staff person. The BH menu of options will be in the *Getting Started with MDPCP* Guide and is very similar to the BH options menu under CPC+.

## Attribution of Beneficiaries

**1. How will CMS attribute beneficiaries to practices?**

CMS will use a prospective attribution methodology to identify the beneficiaries expected to be served by a Participant Practice. CMS will use Medicare claims filed during the prior 24 months to determine the Participant Practice to which beneficiaries will be attributed. For beneficiaries who have received Chronic Care Management (CCM) services, an Annual Wellness Visit (AWV), or a Welcome to Medicare Visit (WMV) over the past 24 months, CMS intends to attribute beneficiaries to the Participant Practice that most recently billed for one of those services on the beneficiary's behalf. CMS intends to attribute all other beneficiaries to the Participant Practice of the primary care provider who billed for the plurality of their allowed primary care visits during the most recent 24-month period for which claims data are available. Dual eligible beneficiaries who are enrolled in Medicaid Chronic Health Homes are excluded from the MDPCP attribution and will not be attributed to a Participant Practice for purposes of the MDPCP.

**2. When are beneficiaries attributed to practices?**

Attribution will be performed annually. Attribution will be prospective based on historical Medicare claims data. Participating practices will remain responsible for their prospectively attributed beneficiaries throughout the performance year, regardless of where the beneficiaries go for care during the performance year itself.

**3. When will CMS update attribution of beneficiaries during the year?**

CMS will update the attribution list on a quarterly basis.

**4. How will practices know which beneficiaries are attributed to them?**

The attribution reports will be sent to the practice on a quarterly basis via the MDPCP Portal.

**5. What are the three payment elements of the MDPCP?**

### Care Management Fee (CMF)

Both tracks provide a non-visit based CMF paid per beneficiary per month (PBPM). The amount is risk-adjusted for each attributed beneficiary in the practice to account for the intensity of care management services required for the practice's specific population. The CMFs will be paid to the practice in advance on a quarterly basis.

The Medicare Care Management Fees average \$17 per beneficiary per month (PBPM) across 5 risk tiers in Track 1 based on HCC scores. The CMFs average \$28 PBPM across 5 risk tiers in Track 2 based on HCC, which includes a \$100 CMF for "complex" patients. The actual payments will depend on the risk score tiers for patients attributed to the practice. At the moment the Model is designed around Medicare FFS and Dual Eligible beneficiaries with the intent of it expanding for all-payers. Other payers do not have to follow this CMF PBPM fee structure and payments may be lower since the acuity level for patients may be lower. CMFs are based on HCC scores.

### Performance-based Incentive Payment (PBIP)

The MDPCP will prospectively pay and retrospectively reconcile a performance-based incentive payment based on how well the practice performs on patient experience measures, clinical quality measures, and utilization measures that drive total cost of care. The performance-based incentive payment will be paid to the MDPCP practice on an annual basis.

### Payment under the Medicare Physician Fee Schedule

Track 1 continues to bill and receive payment from Medicare FFS as usual. Track 2 practices also continue to bill as usual, but the FFS payment for evaluation and management services will be reduced to account for CMS shifting a portion of Medicare FFS payments into Comprehensive Primary Care Payments (CPCPs), which will be paid in advance on a quarterly basis. The manner in which the CPCP is calculated is discussed in a separate FAQ.

#### *MDPCP Financial Summary Table*

Track	Care Management Fees (PBPM)	Performance-Based Incentive Payments	Payment under Medicare Physician Fee Schedule
1	\$17 average	Utilization and Quality/ Experience Components	FFS
2	\$28 average	Utilization and Quality/ Experience Components	↓ FFS + ↑ CPCP

## CMF Payments

### **1. How does a practice know how much they will get paid?**

Care Management Fee (PBPM) for track 1 and track 2 practices will be on average \$17-\$28 based on the risk scores of the attributed patients. Tiered payments based on acuity/risk tier of patients in practice up to \$100 to support patients with complex needs. Please see Table 1 below for



details on tiers and payments. The risk scores, tiers and payments will be provided in the MDPCP Portal in advance of each quarter.

**2. Is there beneficiary cost-sharing for the CMF?**

No.

**3. When will payments be made?**

Payments are made prospectively on a quarterly basis.

**4. What happens if a provider bills for CCM?**

Given the similarity in services between MDPCP and Chronic Care Management (CCM), practices in both tracks will not be permitted to bill the CCM for attributed beneficiaries. Any revenue from CCM for beneficiaries attributed under the MDPCP will be subtracted from MDPCP CMF payment.

Table 1: CMF Tiers and Payments

Beneficiary CMFs will be based on CMS' hierarchical condition category (HCC) risk scores and claims data for diagnoses. Risk-tier cutoffs will be determined using a regional pool of Medicare FFS beneficiaries. There will be five beneficiary risk tiers, which includes a "Complex" tier for attributed beneficiaries either in the top 10 percent of HCC risk scores or with persistent and severe mental illness, substance use disorder, or dementia.

	Track 1		Track 2	
Risk Tier	Criteria	PBPM CMF	Criteria	PBPM CMF
Tier 1	01-24% HCC	\$6	01-24% HCC	\$9
Tier 2	25-49% HCC	\$8	25-49% HCC	\$11
Tier 3	50-74% HCC	\$16	50-74% HCC	\$19
Tier 4	75-89% HCC	\$30	75-89% HCC	\$33
Complex	90+% HCC or persistent and severe mental illness, substance use disorder or dementia	\$50	90+% HCC or persistent and severe mental illness, substance use disorder, or dementia	\$100

For examples of HCC risk tiers from the Comprehensive Primary Care Plus (CPC+) program, see page 89 of the CPC+ Financial Methodology document, available at: <https://innovation.cms.gov/Files/x/cpcplus-methodology.pdf>.

CMF payment amount will be dependent on patients' HCC scores and corresponding risk tier. Correct diagnosis coding is essential to ensure that HCC scores for your patients are calculated

appropriately and you receive appropriate CMF payment benefit for higher-risk patients with multiple-comorbidities.

## Performance-Based Incentive Payment (PBIP)

### **1. How will CMS calculate the PBIP?**

To encourage and reward accountability for patient experience, clinical quality, and utilization, CMS will pay the PBIP prospectively, but Participant Practices will be required to repay unearned payments, and will thus be “at risk” for the amounts prepaid.

### **2. What are the two distinct components of the PBIP?**

The PBIP will be broken into two distinct components, both paid prospectively:

- (1) incentives for performance on clinical quality and patient experience measures, and
- (2) incentives for performance on hospital and emergency department utilization measures.

The first quality/experience component will be based on performance on the eQMs and Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) metrics.

The second utilization component will be based on claims-based measures of inpatient admissions and ED visits, which are available in the Healthcare Effectiveness Data and Information Set (HEDIS) and will be made available to practices to track their performance.

### **3. Is quality a prerequisite for the PBIP?**

The PBIP considers quality an absolute prerequisite, such that participant practices cannot receive their utilization-based PBIP unless they meet the minimum quality performance requirements. Practices will receive larger PBIPs in Track 2 than in Track 1. Practices may keep all or a lesser amount of than these amounts, depending on their performance. The final methodology will be outlined in more detail the Practice Participation Agreement.

### **4. What are the PBIP payments by Track?**

	Utilization (PBPM)	Quality (PBPM)	Total (PBPM)
Track 1	\$1.25	\$1.25	\$2.50
Track 2	\$2.00	\$2.00	\$4.00

### **5. How will CMS pay participant practices?**

CMS will pay prospectively the entire amount at the beginning of the performance year. CMS will pay participant practices' PBIPs based on their performance on each individual eQm and utilization measure, but in order to achieve payment for utilization, quality must first be met. The payment is made as a single payment in advance of the program year.

### **6. How is a practice eligible to retain the PBIP?**

In order to be eligible to retain the PBIP, a participant practice must successfully and completely report on nine MDPCP eQMs, to be specified in the MDPCP Participation Agreement. Practices are encouraged to report all 19 measures. The payment for each measure will be based on performance compared to national benchmarks. Practices may keep all, some, or none the incentive payments based on their performance on quality and utilization measures.

**7. How will CMS score payments?**

CMS will score payments using a continuous approach with a threshold minimum of 50%. Practices meeting less than 50% of their performance threshold keep none of the incentive; practices meeting 80% or more of their performance threshold keep the entire incentive. A 60% score results in the practice keeping 60% of their payment. Further information from CMS will be provided in a comprehensive attribution and payment document that will be available to the practices before the start of the MDPCP.

**8. How often will measures change?**

Measures will be revisited annually and participant practices will be notified of methodological changes prior to the performance year in which changes will take effect.

**9. Will CMS publish results of practice's quality measures?**

CMS will publish comparative performance results to all MDPCP participant practices to motivate the practices to perform well compared to their peers. CMS hopes this will spur competition between practices, potentially yielding greater improvements in quality. Practices must agree to have their quality outcomes published as a condition of participation.

## Comprehensive Primary Care Payments (CPCP)

**1. How does the CPCP payment work?**

Medicare FFS payments will remain unchanged in Track 1. In Track 2, to support practices in delivering even more comprehensive care, CMS will pay participant practices in a hybrid fashion, with part of payments made on a prospective capitated PBPM basis (CPCP) and part paid under a reduced FFS amount. To allow practices to gain experience with this hybrid payment model, during their first year of participation in the MDPCP, Track 2 practices may select either a 10% upfront CPCP payment (with 90% of the applicable FFS payment) or a 25% upfront CPCP payment (with 75% of the applicable FFS payment) or other blends as depicted in the chart below. Track 2 practices must increase the prospective capitated portion to at least 40% by the third year in track 2. The practice can not choose an option with a lower CPCP amount in subsequent years. These payment options will change based on how long the practice has been participating in the initiative, as shown in the table below. By their end of their third year in the initiative, all track 1 practices must transition to a Track 2 practice and thus choose one of the CPCP options.

	Yr1 in MDPCP Track 2	Yr2 in MDPCP Track 2	Yr3+ in MDPCP Track 2
Percent of E&M	10% / 90%	N/A	N/A

Revenues through CPCP	25% / 75%	25% / 75%	N/A
versus	40% / 60%	40% / 60%	40% / 60%
Percent of E&M Revenues through FFS	65% / 35%	65% / 35%	65% / 35%

## 2. How will CMS calculate the CPCP?

Medicare FFS payments will be reduced in an amount commensurate to the amount prepaid in the CPCP. The CPCP and reduced FFS payments will only apply to Medicare payments for E&M services. When computing the CPCP, CMS adds 10% to Track 2 practices' historical payments for E&M services. The 10% increase reflects the increased depth and breadth of care that participating practices are expected to deliver in Track 2. The assessment of these services' value at 10% of historical E&M revenue is informed by Section 5501(a) of the Affordable Care Act on Incentive Payments for Primary Care Services.<sup>1</sup> Total compensation is set at 110% of the standard Provider Fee Schedule, so practitioners receive a 10% increase on their historical E&M payments. The amount of each quarterly payment will depend on the percentage selected to be paid prospectively through CPCP.

For more information on how practice payments are calculated, see the MDPCP mini-webinar series at: <https://health.maryland.gov/mdpcp/Pages/practices.aspx>.

## 3. When will the CPCP be paid to practices?

CPCP is paid prospectively on a quarterly basis.

## 4. How will a practice know what its CPCP payments will be?

Practices will be provided information on CPCP payment amounts through the MDPCP Portal at the beginning of each quarter.

## Quality Measures

### 1. How are the quality measures reported to CMS?

Quality measures will be reported by practices using a state designated process in conjunction with CRISP, the state-designated Health Information Exchange (HIE), that enables the ability to report eQMs.

### 2. What quality measures are included in the program?

MDPCP eQMs will be specified in the MDPCP Participation Agreement.

### 3. Why will CMS publish comparative quality measures?

<sup>1</sup> Polsky, D. et al. (2015) Appointment availability after increases in Medicaid payments for primary care. *New England Journal of Medicine*. Feb 5;372(6):537-45.

CMS will publish comparative performance results to all MDPCP participant practices to motivate the practices to perform well compared to their peers. CMS hopes this will spur competition between practices, potentially yielding greater improvements in quality.

**4. What happens if a practice does not want their quality measures to be shared with other practitioners?**

Practices must agree to have their quality outcomes published as a condition of participation.

**5. Will the quality measures change?**

Measures will be revisited annually.

**6. How will practices know when the quality measures change?**

Participant practices will be notified of methodological changes prior to the performance year in which changes will take effect.

## **Care Transformation Organizations (CTOs)**

**1. What is a CTO?**

A CTO is defined as an entity that hires and manages an interdisciplinary care management team capable of furnishing an array of care coordination services to Maryland Medicare beneficiaries attributed to Participant Practices. CTOs will be required to maintain a governance board which includes primary care practitioners who are employed by their partner practices. The governance structure of the CTO will be laid out in the CTO Participation Agreement. The CTO must sign a CMS Participation Agreement to participate in the MDPCP.

**2. Can a CTO also be an ACO?**

The CTO Participation Agreement will not explicitly prohibit the CTO from being an ACO. The ACO must however meet the requirements set forth in the participation agreement including the governance structure and maintaining separate accounting.

**3. Are there any restrictions on ownership of a CTO?**

There should not be any restriction on ownership of the CTO. For example, a health system could own a CTO and own an ACO so long as the individual business units adhere to the governance and other requirements in the participation agreement.

**4. How do practices partner with a CTO?**

Practices will be free to choose the participating CTO they wish to partner with, subject to certain geographic and capacity limitations that will be indicated by each CTO as part of their application. Practices will be provided with a preliminary list of participating CTOs prior to completing their application. Practices will select both a primary and secondary CTO selection in the case that the primary choice is not available (e.g. geographic or capacity limitations do not allow the practice to partner with their primary CTO selection).

**5. Are CTOs required to partner with any practice that requests to partner with them?**

Yes. CTOs must partner with any participating practice that wishes to partner with them subject to certain geographic and capacity limitations that will be negotiated between CMS and each CTO during the CTO application process.

**6. How does a CTO assist its MDPCP partner practice(s)?**

CTOs will assist MDPCP practices in meeting the Care Transformation Requirements. Practices may utilize the CTO's staff that it has available for deployment. The CTO's deployed staff will operate at the general direction of the practice physicians and will serve as care management staff that the practice may direct towards MDPCP activities. The services furnished by the CTO's deployed staff (care management team) on behalf of participating partner practices will be "incident to" the professional services of the partner practice(s)' physicians (or other practitioners), and will be carried out under the direct or general supervision of one such physician (or other practitioner) appearing on the practice's roster of practitioners.

Practices can continue to bill Medicare for Transitional Care Management (TCM) Services, Annual Wellness Visits (AWV) and other similar services, but may not bill separately for services that are paid for under the CMF payments. For additional guidance and examples of behavioral health billing under the CPC+ program, please see pages 7-8 of the CPC+ FAQs, available at: <https://innovation.cms.gov/Files/x/cpcplus-practiceapplicationfaq.pdf>.

**7. What services must a CTO provide?**

In performing services integral to meeting one or more of the partner practice's Care Transformation Requirements, a CTO may only provide services to a partner practice's beneficiaries that fall within the following categories:

- 1) *Care Coordination Services*
- 2) *Support for Care Transitions*
- 3) *Standardized Screening*
- 4) *Data Tools and Informatics*
- 5) *Practice Transformation Assistance*

**8. How are CTO payments structured?**

CTO Payment Option 1

The CTO will receive 50 percent of the CMF payment; the remaining 50 percent of the CMF will be paid to the partner Participant Practice. Under Option 1, the CTO will provide each partner Participant Practice with at least one Lead Care Manager for every 1000 attributed Medicare FFS beneficiaries. The Lead Care Manager is defined as an individual who is fully dedicated to care management functions of the Participant Practice under the MDPCP. Under Option 1, the Lead Care Manager must be a full-time employee (FTE) of the CTO. The Lead Care Manager must work with participant practitioners in the practice who have primary responsibility for care management of all beneficiaries attributed to the practice. The CTO may provide additional care management personnel as necessary to fulfill specialized care management needs that the practice may have.

### CTO Payment Option 2

The CTO will receive 30 percent of the CMF; the remaining 70 percent of the CMF payment will be paid to the partnering Participant Practice. Under Option 2, the partner Participant Practice has its own Lead Care Manager, so the CTO does not need to deploy a Lead Care Manager to the practice. However, the CTO will provide the practice with access to an interdisciplinary care management team. The CTO's interdisciplinary care management team and additional support will supplement the Lead Care Manager who is employed by the practice.

**9. Is the CTO responsible for meeting any of its partner practice's Care Transformation Requirements?**

The CTO will assist its partner practices in meeting the Care Transformation Requirements. Meeting the Care Transformation Requirements is ultimately the responsibility of the practice.

**10. What happens if a CTO does not assist a partner practice in meeting the Care Transformation Requirements?**

If a CTO does not effectively assist its partner practice in meeting the Care Transformation Requirements, CMS may put the CTO on a corrective action plan in accordance with the terms of the CTO's CMS participation agreement.

**11. When may a practice choose to partner with a different CTO or choose to work independently?**

Each year, at a time and in a manner specified by CMS, practices may request to switch CTOs or choose not to partner with any CTO.

**12. When can a CTO adjust the practice capacity stated on its original application?**

CTOs will have the opportunity to declare a new practice capacity amount annually.

## HIT Requirements

**1. What Electronic Health Records are acceptable for the practice to use?**

The practice must use a 2014 or later edition certified EHR technology, with a commitment to transition to a 2015 or later edition certified EHR technology. This requirement may be updated to be consistent with future Quality Payment Program requirements.

**1. Does the EHR requirement satisfy the meaningful use regulations and the EHR requirement for QPP?**

The MDPCP will require 100% of eligible clinicians in participating practices to use CEHRT as defined in 42 CFR § 414.1305 to document and communicate clinical care to their patients or other health care practitioners. The MDPCP EHR requirements satisfy the Quality Payment Program requirements for an advanced alternative payment model (AAPM).

**2. What connectivity with CRISP is required to be accepted into the program?**

Practices will need to achieve bi-directional connectivity with a Health Information Exchange by the end of the practice's first year of participation in Track 2 of the MDPCP. Practices will

commit to this using a signed letter with CRISP and submit in their application. Instructions for requesting a letter of support from CRISP, as well as a downloadable letter template, are available at: <https://health.maryland.gov/mdpcp/Pages/practices.aspx>

## Learning System

### **1. What learning and technical assistance supports will the MDPCP offer to participating practices?**

The MDPCP will offer participating practices a variety of learning opportunities to support their transformation needs with in-person, virtual, and on-demand events and information. The learning community will provide the MDPCP practices with opportunities for in-person and web-based learning. Learning events and materials will orient practices to MDPCP requirements and guide practices through the MDPCP five comprehensive primary care functions. Online collaboration tools and web-based tools will facilitate practice sharing. The learning community will also offer targeted, practice-level technical assistance to support practices to enhance their capabilities.

## Data

### **1. What data will be made available to practices?**

CMS will offer Participant Practices the opportunity to request practice-level and certain beneficiary-level Medicare beneficiary data (Parts A and B claims) for use in care management and other clinical activities. CMS will provide Participant Practices that request such data with quarterly practice-level feedback reports. The reports will summarize Medicare FFS cost and utilization, as well as provide beneficiary-level lists of ED visits, hospitalizations, and other high-cost services (e.g., imaging) used during the previous calendar quarter. CMS will also offer reports of cost and quality data about subspecialists to help Participant Practices select cost-effective specialty partners. Finally, practices will receive operational data including a list of attributed Medicare beneficiaries and prospective payment amounts based on number of attributed Medicare beneficiaries (CMF and PBIP).

## Billing

### **1. Will MDPCP practices be allowed to bill chronic care management, collaborative care model, and behavioral health integration codes?**

Specific details regarding billing of certain codes for attributed beneficiaries under MDPCP will be provided in program materials later this year. Practices may continue to bill all of these codes for their unattributed beneficiaries. For additional guidance and examples of billing under the CPC+ program, please see pages 7-8 of the CPC+ FAQs, available at: <https://innovation.cms.gov/Files/x/cpcplus-practiceapplicationfaq.pdf>.